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Issue Date: 26 March 2004

CASE NO.: 2002-LHC-967

OWCP NO.: 08-115422

IN THE MATTER OF:

LARRY CHAUVIN (DECEASED)[1]

Claimant

v.

EXXON MOBIL CORPORATION

Employer

and

PETROLEUM CASUALTY COMPANY

Carrier

APPEARANCES:

QUENTIN D. PRICE, ESQ.
ED W. BARTON, ESQ.

For The Claimant

IRA J. ROSENZWEIG, ESQ.

For The Employer/Carrier

Before: LEE J. ROMERO, JR.
Administrative Law Judge

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[1] It is undisputed that Harriet and Margaret Chauvin are the surviving spouse and child of Mr. Chauvin, who died on October 5, 1998. (Tr. 18). For the purposes of explication, Mr. Chauvin is referred to as "Decedent," while the survivors are referred to as "Claimants."

DECISION AND ORDER DENYING BENEFITS

This is a claim for death benefits under the Longshore and Harbor Workers' Compensation Act, as amended, 33 U.S.C. § 901, et seq., (herein the Act), brought by Harriet Chauvin and Margaret Chauvin (Claimants) on behalf of Larry Chauvin (Decedent) against Exxon Mobil Corporation (Employer) and Petroleum Casualty Company (Carrier).

The issues raised by the parties could not be resolved administratively and the matter was referred to the Office of Administrative Law Judges for hearing. Pursuant thereto, Notice of Hearing was issued scheduling a formal hearing on September 16, 2003, in Lafayette, Louisiana. All parties were afforded a full opportunity to adduce testimony, offer documentary evidence and submit post-hearing briefs. Claimants offered 29 exhibits, 26 of which were received. Claimants' exhibit number 20 (documents from the United States Coast Guard relating to its availability and capabilities), number 23 (National Institutes of Health (NIH) Internet pages) and number 29 (Internet page exhibits attached to Dr. David Baker's deposition) were reserved for ruling in this Decision and Order. Employer/Carrier proffered 5 exhibits which were admitted into evidence along with one Joint Exhibit.[2] At the conclusion of the formal hearing, the record was closed and the parties were directed to submit post-hearing briefs by November 3, 2003.

On November 14, 2003, after an extension of time within which to file post-hearing briefs, the parties submitted post-hearing briefs. Based upon a full consideration of the entire record, the stipulations of the parties, the evidence introduced, my observations of the demeanor of the witness, and having considered the arguments presented, I make the following Findings of Fact, Conclusions of Law and Order.

I. STIPULATIONS

At the commencement of the hearing, the parties stipulated (JX-1), and I find that:

1. Decedent died on October 5, 1998.

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[2] References to the transcript and exhibits are as follows: Transcript: Tr.___; Claimants' Exhibits: CX-___; Employer/Carrier's Exhibits: EX-___; and Joint Exhibit: JX-1.

2. There existed an employee-employer relationship at the time of the accident/injury.

3. Employer was aware of the alleged accident/injury on October 5, 1998.

4. The Act applies to this matter.

5. Employer/Carrier filed a Notice of Controversion on October 29, 1998.

6. An informal conference before the District Director was held on September 25, 2001.

7. Decedent's average weekly wage at the time of his accident/injury was $1,466.24.

8. Employer/Carrier have paid no benefits.

9. Claimants are Decedent's surviving spouse and surviving child. (Tr. 18).

II. ISSUES

The unresolved issues presented by the parties are:

1. Causation; whether Decedent's heart attack is occupationally related.

2. Attorney's fees, penalties and interest.

III. STATEMENT OF THE CASE

The Testimonial Evidence

Harriet Chauvin

Mrs. Chauvin testified she and Decedent married on March 30, 1968, and continued living together as husband and wife through Decedent's death on October 5, 1998. She and Decedent obtained legal custody of Margaret, who is their granddaughter, and were in the process of adopting Margaret when Decedent died. Margaret lived with Decedent and Mrs. Chauvin for approximately eight or nine years and was nearly ten years old upon Decedent's death. Mrs. Chauvin and Margaret were dependent upon Decedent for support. Margaret received some disability related to a

birth defect. According to Mrs. Chauvin, Decedent experienced no stress at home or in his life. There were no marital or emotional disputes. Decedent was "thrilled to be home" because he "loved his home, his garden, [and] his children that all lived right around him." (Tr. 24-32).

Mrs. Chauvin stated Decedent experienced debilitating chest pains at work approximately a "couple of years" before 1998, and Employer allowed him to drive himself six hours home for treatment. Dr. Baker inserted a stent the following day. A few months later, Dr. Baker inserted another stent and released Decedent to return to work. (Tr. 28-29, 46-47).

Dr. Baker recommended walking exercises and lifestyle changes for Decedent. Mrs. Chauvin modified Decedent's diet to include less seafood. Decedent, who formerly purchased one carton of cigarettes before each period of offshore work, quit smoking cigarettes, but continued purchasing cigars which he did not inhale but used "just to have something in his hand." He used roughly two cigars weekly around the house. (Tr. 28-29).

According to Mrs. Chauvin, Decedent went into management five years before his death. Management was stressful for him because he did not like directing, evaluating and disciplining his colleagues at work. He often complained of voluminous paperwork and impending deadlines which would keep him awake late at night after working all day. He discussed added pressure related to insuring compliance with environmental regulations. He was not computer literate, but was required to work with computers and different software programs which gave him stress. He often described being understaffed on platforms, which required him to work on multiple rigs on different days. His sense of responsibility and desire to complete jobs also caused him stress. He was in management when he suffered his original chest complaints which warranted his stent insertions. (Tr. 33-39, 48).

Mrs. Chauvin spoke to Decedent every night around 8:00 p.m. when Decedent was aboard platforms. On the day prior to his death, Decedent was not feeling well. (Tr. 29-30). Mrs. Chauvin testified Decedent told her Employer's helicopter policy was inefficient. He indicated he would call the United States Coast Guard (USCG) if any employee would become injured while he was on watch because the USCG was closer and provided medical capabilities. (Tr. 39-40).

On cross-examination, Mrs. Chauvin testified that Decedent did not complain about work or climbing stairs on the night he died. She indicated Decedent often discussed retiring, but could not afford the costs related to childcare, utilities and insurance. (Tr. 41–48).

The Medical Evidence

David G. Baker, M.D.

On January 15, 2003, Dr. Baker, who is Board-certified in internal medicine and cardiovascular disease, was deposed by the parties. He treated Decedent for his ongoing heart condition since December 1997, when Decedent was referred to him by Dr. Kirtland Swan. (CX-29, pp. 5-6, 54).

On December 16, 1997, Decedent initially presented with a history of chest discomfort and heart pain that occurred with exertion over the previous few weeks with activities such as moving potted plants or "walking up a platform at work." Decedent's pain was relieved with rest. Dr. Baker diagnosed unstable and progressive angina. He performed a catheterization, which revealed coronary artery disease involving two of the three major branches of the heart arteries. Decedent had multiple arterial blockages of 60, 75 and 95 percent at various locations in the right coronary artery, while he had a 75-percent blockage in the anterior descending artery. (CX-4, pp. 12-14, 50; CX-29, pp. 7-11).

On December 18, 1997, Dr. Baker inserted arterial stents without complication. At that time, Dr. Baker opined Decedent suffered from coronary atherosclerotic heart disease which involves a very complicated plaque that impedes blood flow within the arteries. The cause of the disease is "not known. Whoever determines that will get the Nobel Prize." However, there are five well-documented risk factors: (1) family history; (2) cigarette smoking; (3) high blood pressure; (4) diabetes; and (5) elevated cholesterol. Decedent demonstrated multiple risk factors, including an approximate 40-year history of smoking a pack and a half of cigarettes daily and a moderate degree of elevated cholesterol. (CX-29, pp. 11-14).

Dr. Baker opined Decedent's disease is generally a chronic disease unless there are dramatic lifestyle changes. The multi-focal nature of Decedent's disease implied a greater likelihood of recurrence. Dr. Baker was unaware of any evidence indicating Decedent's coronary artery disease was occupationally related,

nor did he observe any evidence that Decedent's work caused any permanent heart damage. (CX-29, pp. 14-15).

On February 2, 1998, Decedent returned to Dr. Baker for follow-up treatment, including a stress test to determine physical limitations. The stress test was generally normal without evidence of residual arterial blockage. On March 30, 1998, Decedent returned with complaints of increased chest pains. Dr. Baker diagnosed recurrent angina and recommended a repeat catheterization. (CX-29, pp. 16-18).

On April 1, 1998, catheterization revealed a restenosis, or narrowing inside the stents. Dr. Baker explained that restenosis is "not actually the atherosclerotic process," but is rather "like a scar tissue" which occurs in arteries at stent locations. Approximately 20 percent of patients undergoing stent insertion experience restenosis which requires a repeat surgical procedure. Dr. Baker noted restenosis historically occurs within two and one half to three months, which is consistent with the occurrence of Decedent's restenosis nearly three months post-surgery. Dr. Baker opined restenosis is not necessarily indicative of individuals who are more likely to experience increased coronary complaints. On April 1, 1998, Dr. Baker successfully re-dilated Decedent's stents. He prescribed medication and recommended a follow-up visit within three months.[3] (CX-29, pp. 18-21).

On June 18, 1998, Decedent returned to Dr. Baker, who found Decedent stable upon physical examination. Dr. Baker recommended a stress test within three months. On August 13, 1998, Decedent underwent a stress test at which he "did well." (CX-29, pp. 21-22).

Dr. Baker opined Decedent's ongoing use of cigars rather than cigarettes was "certainly" more significant than not using any tobacco products at all, which Dr. Baker recommends to all of his patients. He agreed with the findings of a Texas medical examiner's "Circumstances of Death" report indicating Decedent died from coronary artery disease. He reviewed Decedent's drug screen, which did not indicate Decedent was using aspirin at the time of death; however, the minimal amounts of aspirin Dr. Baker

[3] Dr. Baker opined Decedent could return to full duty work after a "brief period" of off-duty employment status, although he did not identify the period of time in which Decedent was briefly disabled. (CX-29, p. 21).

recommends to his patients would not necessarily be revealed in a drug screen. (CX-29, pp. 22-24).

Assuming Decedent's episode began around 2:00 a.m., Dr. Baker had no indication Decedent's work contributed to his heart attack. He added, "As a matter of fact, most heart attacks occur in the early morning hours and awaken patients from sleep." According to Dr. Baker, such heart attacks are unrelated to activity and occur from the natural development of coronary artery disease. (CX-29, p. 24).

On cross-examination, Dr. Baker opined stress is not a causative factor in heart disease, although stress may cause symptoms from blockage which is already present due to other causes. Dr. Baker denied Claimants' Counsel's interpretation of an Internet web page to mean stress might be a causative factor in the development of heart disease. Dr. Baker explained stress is not an independent risk factor according to all of the medical literature he has reviewed. Rather, stress stimulates an individual's heart rate, blood pressure and rate of breathing which increases the demand for blood to be pumped by the heart. Consequently, "if you have narrowed arteries, [stress] brings on the symptoms," but does not actually cause the development of atherosclerotic plaque. (CX-29, pp. 24-28, 31, 64).

Dr. Baker noted uncontrolled stress might increase the likelihood of high blood pressure, which is a risk factor in coronary artery disease because it traumatizes arterial lining and increases the propensity for arterial plaque formation. On February 2, 1998, Decedent's blood pressure rose to 148/110 during stress testing, but returned to normal limits after testing. On June 18, 1998, Decedent's blood pressure was elevated at 146/96 when Dr. Baker opined he was probably anxious over test results. Otherwise, Decedent's blood pressure was unremarkable. Dr. Baker opined Decedent was not hypertensive because, "generally when he was relaxed, his blood pressure was normal." (CX-29, pp. 28-33, 42).

Dr. Baker opined that quicker medical treatment is generally better for individuals suffering myocardial infarction, or an obstruction of blood flow to a coronary artery; however, quicker treatment is not necessarily better for patients suffering from cardiogenic shock, which involves the obstruction of a blood vessel supplying more than 60 percent of the heart muscle. Dr. Baker explained the effects of cardiogenic shock, which has a mortality rate "upwards of 80 percent," are "rarely" reversed. He opined Decedent likely

suffered cardiogenic shock because Decedent experienced angina which was not relieved through the initial use of nitroglycerine, which can lower blood pressure. He opined an autopsy would establish the degree of Decedent's blockage but would not necessarily indicate cardiogenic shock, which is a clinical term rather than an autopsy term. (CX-29, pp. 33-36, 46-47).

Dr. Baker opined it is difficult to estimate with any certainty how long medical treatment may be commenced after the onset of a heart attack because it is difficult to know whether an individual is suffering simple angina or experiencing the effects of an occluded artery. He opined defibrillators are generally very effective at treating many victims of heart attacks because the majority of patients who die from heart attacks die within the first two hours from ventricular fibrillation, or an "electric death." The American Heart Association recommends most facilities offer the devices because the devices are so effective. Although it is "conceivable" Decedent might have benefited from a defibrillator, Dr. Baker opined it is impossible to know whether Decedent would have been assisted by a defibrillator. (CX-29, pp. 34-36).

Dr. Baker disagreed that individuals should generally seek less stressful jobs or retire to avoid stressful employment. He explained there is no job without any stress, and "frequently we find that patients who retire have more stress than they did while they were at work." He generally recommends patients should change their responses to stress in such a manner that blood pressure is less affected. In response to a question regarding what evidence would be required to establish Decedent's "employment was related to his heart attack and ultimate death," Dr. Baker explained, "I don't know of any job that causes coronary artery disease . . . There's no particular job that is associated with a higher incidence of coronary disease than any other." (CX-29, pp. 36-38, 58).

Dr. Baker denied exercise would cause damage to Decedent's heart prior to the stent insertions. Rather, he indicated exercise, which raises "HDL, . . . the so-called good cholesterol level," was advisable because it is "good for coronary disease." He opined Decedent experienced chest pains upon any exertion because his arteries were clogged with plaque, which impeded increased blood flow necessary for physical exertion. He concluded Decedent exhibited no heart damage upon initial treatment because "his heart muscle function was normal on the first angiogram." Likewise, he discovered no evidence of

heart damage during Decedent's ongoing medical treatment. He noted heart damage occurs with blockage "only if the blockage is complete and abrupt and [individuals] have a heart attack." (CX-29, pp. 38-41, 47-48).

On re-direct examination, Dr. Baker opined it was "impossible" to know what stresses Decedent experienced because Decedent reported no history of any stresses which were bothering him. He could not opine whether the body and heart would relax within two hours after an adrenaline-producing episode of emotional stress; however, depending on the level of physical exertion, he opined most patients would return to a restful state within two hours following physical exertion. Dr. Baker opined Decedent's adrenaline level likely subsided by the time he went to sleep on October 5, 1998. (CX-29, pp. 42-44).

Dr. Baker explained that a current theory regarding the general relationship between exercise and nightly heart attacks indicates some individuals with "atherosclerotic plaque that's lipid rich" experience stresses during the day, when adrenaline levels increase, violating the "lipid-rich plaque" and causing the clotting process to "take over" during the remainder of the day. The clotting process continues into the night and concludes with a heart attack when most people are sleeping or otherwise at rest. Dr. Baker had no information suggesting this occurred in Decedent's case. (CX-29, pp. 44-46).

On further examination, Dr. Baker indicated stair-climbing may be a strenuous activity which could be considered to determine whether or not there is a relationship between daytime physical activity and nightly heart attacks. Assuming Decedent performed "some reasonable amount of stair climbing" for what he understood oil workers to perform, Dr. Baker, who noted he was not aware of Decedent's daytime physical activities, opined stair climbing did not cause Decedent's heart attack. However, he relied on the theoretical relationship between daytime activities and nightly heart attacks and added, "After you tell me he was running up and down the stairs several hours prior to going to sleep, then I would say that [it] would be plausible that that's [sic] what happened." (CX-29, pp. 46-50).

Notwithstanding the theoretical relationship between daytime activity and nightly heart attacks, Dr. Baker opined it is impossible to say whether Decedent's stair-climbing was related to his fatal heart attack. He concluded Decedent's plaque ruptured to cause the fatal clotting process, but could not offer any opinion on what caused the plaque to rupture. He

opined, "The only way to know for certain is if [Decedent] had an autopsy." (CX-29, pp. 50-51).

Arthur B. Simon, M.D.

On August 14, 2003, the parties deposed Dr. Simon, who is Board-certified in internal medicine and cardiovascular disease. Dr. Simon has practiced since 1972. He has worked in private practice, taught cardiology and published numerous articles related to pre-hospitalization emergency cardiac care, and currently works as a consultant in the cardiology department at Dean Health Systems in Madison, Wisconsin. He performs angiograms to identify arteriosclerosis, but does not perform angioplasty. He is experienced in treating coronary risk factors through the use of exercise, aerobic programs, cholesterol control, smoking cessation and family counseling. He was hired by Claimants' Counsel to render medical opinions related to Decedent's heart attack. (CX-17, pp. 1-10).

On June 30, 2003, Dr. Simon prepared a medical report after he reviewed Decedent's medical records, a medical examiner's inquest report, the statements of Gary Priddy, William Teel, Marshall Satterwhite, Larry Fortenberry and Dr. O'Meallie's November 13, 2002 medical report. His opinions in his report and in his deposition are within a reasonable degree of medical probability. (CX-17, pp. 10-14; CX-18).

Dr. Simon opined Decedent died from complications related to coronary artery disease. He explained, "Arteriosclerosis is a disease. The precise etiology or cause is not known," but is associated with risk factors, including age, high blood pressure, high cholesterol, obesity, diabetes mellitus, cigarette smoking and family history. According to Dr. Simon, "some people" opine stress may "aggravate or may be an additive in its etiology or cause." The principal manifestations of the disease include: (1) chest pain, or angina, (2) myocardial infarction, or an accumulation of cholesterol deposits in the arteries which become occluded, and ultimately (3) congestive heart failure such as ventricular fibrillation, commonly called a cardiac arrest. (CX-17, pp. 14-15).

Dr. Simon reviewed Decedent's offshore platform supervisor job descriptions and opined Decedent's job was a sedentary position, or a "desk job intermittently interrupted by the need to climb stairs . . . ." He concluded Decedent "was confined during his job to a relatively small area that, although there was exercise equipment available, his job itself involved stair-

climbing and desk work." He opined Decedent's employment contributed to his underlying coronary artery disease because of multiple factors: (1) "certainly the job itself does not per se result in all these risk factors, [b]ut we know that a basic sedentary lifestyle or the absence of aerobic effort . . . aids or causes a progression of the disease;" and (2) Decedent's isolation from medical care on an offshore platform impeded the receipt of proper medical treatment. (CX-17, pp. 15-18).

Dr. Simon reviewed Mr. Teel's statement indicating "heart-healthy meals" were available for workers aboard the platform. He noted the concept of "heart healthy," which generally implies a reduction in fat and caloric intake, may differ among individuals. He observed Decedent, who was overweight when he was first diagnosed with coronary disease, continued gaining weight until his death, indicating Decedent was not necessarily eating a heart healthy diet. Dr. Simon opined a heart healthy diet alone is not necessarily helpful without effort, training and education in food selection and quantity. For instance, "it doesn't do any good to have a low-cholesterol diet if it's 4000 calories per day." (CX-17, pp. 18-20; EX-4).

Dr. Simon opined Decedent's job was related to his coronary disease because his offshore co-workers were less likely than his wife to insure he adhered to a strict dietary regimen. Likewise, his co-workers would not be as concerned about his exercise, smoking and other risk factors. Dr. Simon noted Decedent's stair-climbing was an isometric exercise, which is "bad for the heart because it raises blood pressure disproportionate [sic] to the amount of muscle activity." On the other hand, he opined aerobic activity, such as walking, improves coronary efficiency and reduces detrimental cholesterol and fats. (CX-17, pp. 20-23).

Dr. Simon indicated Decedent's job was psychologically stressful for Decedent because "repeated situational conditions," including oil spills, and "the necessity for reports and so forth," were beyond his control. Dr. Simon opined psychological job stress contributes to coronary artery disease because the stress raises adrenaline levels which increase a person's heart rate and blood pressure. He noted stress varies among individuals, and "what is one man's stress is not necessarily another man's stress." He also opined loneliness, or emotional isolation, would contribute to coronary artery disease. He conceded he was unable to confirm that Decedent was lonely, but noted he could not imagine "being stuck on an oilrig out in the middle of the Gulf of Mexico for long

stretches of time to be a very emotionally rewarding period. And I just can't fathom somebody being happy in that kind of environment." (CX-17, pp. 23-25).

Dr. Simon testified Decedent exhibited no direct symptoms of a heart attack prior to the episode which awakened him in bed on October 5, 1998. However, he noted Decedent likely suffered "prodromal symptoms" related to the occlusion of Decedent's arteries which did not "narrow over an hour or two. This is a gradual insidious process that occurs over days to weeks." Based on Decedent's co-workers' statements, he opined Decedent exhibited "pre-infarction angina," which is a "common pattern" of prodromal symptoms, including increasing fatigue, increasing shortness of breath, episodes of angina, dizziness, light-headedness and slower movements, before the onset of a heart attack. Such symptoms were indicative of a "pathoanatomic substrate of his heart attack, that is probably restenosis in the site of the previously placed stent." (CX-17, pp. 25-29).

Dr. Simon indicated there are two reasons quick emergency response is better for coronary patients. First, Dr. Simon explained that irreversible coronary damage due to narrowed arteries and restricted blood supplies will occur quickly and reduce the likelihood of recovery. Second, the majority of coronary fatalities occurs quickly due to ventricular fibrillation, which may only be reversed through counter-shock treatment. Dr. Simon estimated that two-thirds of people who die from atherosclerosis die before reaching the hospital due to ventricular fibrillation. (CX-17, pp. 29-30)

Ideally, Dr. Simon explained defibrillators should be employed within three minutes following the onset of fibrillation, which is "almost always fatal if the person is not in a hospital setting or does not have a defibrillator strapped to them such as they might be in an airport or airplane." Any period without defibrillation beyond three minutes after ventricular fibrillation will result in irreversible brain damage. Without defibrillation, the probability of survival diminishes to "almost zero." (CX-17, pp. 30-31).

Dr. Simon opined defibrillators were commercially available in 1998 when Decedent suffered his heart attack. They were not as portable then, but he would have recommended Employer provide the devices aboard rigs, which are generally greater than three minutes from the nearest emergency providers, for employees who might be at their highest risk of ventricular fibrillation. Dr. Simon noted a defibrillator successfully converts ventricular

fibrillation to "normal rhythm" in about 90 percent of circumstances. He explained,

> we don't know how big [Decedent's] heart attack would have been, we don't know how reversible or how much his disease was reversible if we would have defibrillated him successfully and gotten him to a cath [sic] lab, but I can say that he would not have died at the time he did had he been successfully defibrillated in three minutes or less.

(CX-17, pp. 31-34; 70-71).

Dr. Simon speculated that a rescue squad could have been dispatched timely to arrive by 2:15 a.m. or 2:20 a.m., when Decedent could have been "on a monitor either in the back of an ambulance or in the emergency room by the time he defibrillated at approximately 2:45 a.m.," if Decedent had been in an urban area and notified others of symptoms which the others recognized as symptoms of a heart attack at 2:00 a.m. (CX-17, pp. 34-35).

On cross-examination, Dr. Simon indicated he has testified as an expert on behalf of plaintiffs and defendants alike in malpractice, products liability, workmens' compensation and personal injury matters. He has testified as an expert on behalf of plaintiffs more than half of the time. (CX-17, pp. 35-38).

Dr. Simon opined Decedent died either from a restenosis or thrombosis. More likely than not, Decedent suffered from a restenosis, which was previously documented, "leading to myocardial infarction rather than a de novo plaque rupture." He could not be sure of the process without an autopsy. Regardless of the process, Dr. Simon concluded it does not matter whether Decedent suffered from restenosis or thrombosis because "the end stage was the same." He added that Decedent would have been defibrillated and received standard treatment to open his arteries if Decedent had "been within civilization" when he sustained his heart attack. Dr. Simon noted that restenosis is not occupationally related; rather, it is the result of disease intervention. (CX-17, pp. 38-43).

Dr. Simon agreed Decedent suffered a pre-existing condition which was eventually fatal. He also agreed the progression of Decedent's disease involved non-occupational factors, including

continued tobacco use, Decedent's genetic structure, and other risks which were Decedent's "personal responsibility." Nevertheless, he opined Decedent's "work environment contributed to the progression of his disease and obviated or prevented standard medical care from occurring." (CX-17, pp. 41-43).

Dr. Simon acknowledged a cook who could prepare meals according to dietary request was available on the platform. He admitted he had no way of knowing the dietary situation at the platform. He also admitted Employer was not responsible for Decedent's choice to consume less healthy meals if healthy choices were available. He agreed somebody with a history of two treatments for coronary complaints should know to select fruits and vegetables rather than less healthy options. (CX-17, pp. 43-46).

Dr. Simon agreed Employer is not responsible for Decedent's obesity, "except insofar as [Employer], because of his job assignment, places him in an environment where he's more tempted to not follow a diet than if he were under the watchful loving eyes of his wife." He conceded Decedent's wife could have noticed his ongoing weight gain prior to his death. He agreed Employer did not compel Decedent, who should be responsible for his continued tobacco use, to smoke. He added, "But in the same vein I think it's more likely that . . . he didn't smoke cigars at home." He also agreed Employer could not be responsible for Decedent's gender. (CX-17, pp. 46-48).

Dr. Simon conceded Employer provided an exercise bicycle on the platform for people who were "motivated to undertake an exercise regimen." He acknowledged stair-climbing is a partially aerobic exercise. If Decedent "could have had breaks going between the stairs and didn't have to rush up the stairs," there is "no doubt that stair-climbing could be part of a cardiac rehab program." Based on his understanding of Decedent's job description according to his co-workers, Dr. Simon estimated Decedent climbed between 10 and 50 flights of stairs daily. (CX-17, pp. 48-50).

Dr. Simon understood Decedent's psychological stress to be the result of his management position which required working with a "periodic malfunctioning computer" and submitting written reports. He was not aware of the frequency with which Decedent was required to complete his tasks, which included "stair-climbing, inspection and desk reports." He again noted psychological stress, which is a "self-perceived phenomena," differs among individuals who might struggle with it or "thrive

on" it. He noted, "only a psychologist might tell us that if he could interview the deceased." He conceded he did not have any medical evidence that job stress was affecting Decedent in a negative way. (CX-17, pp. 50-57).

Dr. Simon opined Decedent's heart attack could "have of course" occurred at home. However, Dr. Simon explained the "possible" emotional stresses of stair-climbing and report writing coupled with geographic isolation from his primary support system, doctor and medical care were contributing causes of his disease and was "why he was not defibrillated on the day that he had his fatal cardiac arrhythmia." Dr. Simon assumed Decedent could access a telephone on the platform to contact his wife. He agreed most people might find their work environment more enjoyable than their home life. (CX-17, pp. 57-58).

Dr. Simon again opined that isolation, which is more likely to cause unhappiness than having "company," may contribute to heart disease. However, he could not elaborate on the meaning of "isolation" in consideration of working co-workers aboard platforms for twenty years. He agreed crew members were trained in medical treatment, including CPR, but opined such treatment was futile without the aid of a defibrillator. He opined Decedent would have had "a statistical chance" of survival if he would have been in an ambulance, emergency room, coronary care clinic or catheterization laboratory when he suffered his heart attack. (CX-17, pp. 58-65).

Dr. Simon opined Decedent experienced a 45 to 50-minute "window of symptoms" after the onset of his complaints around 2:00 a.m. until his fatal ventricular fibrillation began. He noted Decedent's prior heart complaints caused no muscle damage and that the October 5, 1998 heart attack was his first heart attack. He opined "80 percent of people who have ventricular fibrillation in the field never get to the hospital, so . . . there's only a 20-percent chance that you will make it to the emergency room alive. Half of those patients will die in the hospital." Half of the surviving patients will sustain no neurological damage, while the remaining surviving patients will sustain irreversible damage. (CX-17, pp. 65-70).

Lawrence O'Meallie, M.D.

On September 3, 2003, the parties deposed Dr. O'Meallie, who is Board-certified in internal medicine and cardiology. Dr. O'Meallie is chief of cardiology at Tulane Medical School, where he completed his post-graduate training, residency and

fellowship. He has been in practice for approximately 35 years and continues consulting patients. Dr. O'Meallie was asked by Employer/Carrier's counsel to render an opinion in this matter based on Decedent's medical records, the statements of Mr. Teel and Mr. Priddy and the depositions of Drs. Simon and Baker. (EX-3, pp. 4-6).

Based on Decedent's medical records, Dr. O'Meallie opined Decedent suffered from coronary artery disease which warranted the insertion of arterial stents. Subsequently, Decedent developed restenosis, which is a condition involving arterial occlusion due to scar tissue forming after the insertion of stents. Accordingly, Dr. O'Meallie opined Decedent suffered in March 1998 from a pre-existing coronary atherosclerotic disease involving the deposition of arterial plaque which is vulnerable to rupture, causing an acute myocardial infarction or heart attack. (EX-4, pp. 6-8).

Dr. O'Meallie concluded there was no evidence indicating Decedent's coronary condition was occupationally related. He noted smoking, obesity, high cholesterol, diabetes, hypertension and a positive family history are risk factors associated with coronary artery disease. He opined Decedent was positive for multiple risk factors including, namely that Decedent was overweight, smoked, had high cholesterol, and exhibited mild hypertension and elevated blood pressure. (EX-4, pp. 8-9).

Dr. O'Meallie opined Decedent likely died from "sudden cardiac death," an acute coronary event involving deprivation of coronary blood supply. Ventricular fibrillation probably occurred, although Dr. O'Meallie noted there was no evidence establishing the occurrence of ventricular fibrillation. He also opined Decedent's employment had "nothing to do with his death." Likewise, he concluded Decedent's employment did not contribute to his death. (EX-4, pp. 9-11).

Dr. O'Meallie indicated certain psychological stress may rarely induce sudden death under some circumstances. Similarly, he opined physical stress might very rarely cause sudden cardiac death, but the stress is "usually intense unusual activity . . . that the individual is unaccustomed to." If either psychological or physical stress causes sudden cardiac death, the cardiac event results immediately after experiencing stress. Due to the passage of time between the expiration of Decedent's work day and the onset of symptoms, Dr. O'Meallie opined Decedent's occupational stress had "nothing to do with his heart disease or demise." (EX-4, pp. 11-12).

Dr. O'Meallie concluded that using computers and writing reports would not cause unusual job stress, otherwise "people would be dropping dead by the dozens every day . . . ." He indicated stress is unavoidable and occurs at work or at home. Because Decedent established approximately 20 years of offshore experience and nearly five years of management experience, Dr. O'Meallie opined Decedent was likely very efficient at handling his job and was experienced in handling stressful situations. (EX-4, pp. 12-14).

According to Dr. O'Meallie, Decedent's weight was unrelated to his employment. He observed that Decedent's weight increased until his death. He opined Decedent could have reduced his weight by watching his diet on the "seven days off at home and doing his best to control his diet on the platform." With the exercise bike and helicopter pad aboard the platform, Dr. O'Meallie concluded Decedent could have engaged in aerobic exercises. He also indicated stair-climbing could form a part of a "heart workout." Accordingly, Decedent "could have done significant athletic training" aboard the platform while climbing stairs, walking and biking. (EX-4, pp. 14-19).

Dr. O'Meallie denied loneliness causes heart disease or sudden cardiac death. In 35 years of practice, Dr. O'Meallie visited platforms for many years, estimated treating hundreds of offshore oilfield workers, who generally indicated to him that the "seven on seven off" schedule provided enjoyment and satisfaction related to the flexibility to pursue personal interests and activities. (EX-4, pp. 16-17).

According to Dr. O'Meallie, offshore oilfield workers generally expressed "a good spirit of camaraderie," because the work demands concentration and teamwork to accomplish. While every member of a crew might not like one another, Dr. O'Meallie opined there was nothing "deleterious in terms of psychological stress that makes an oilfield worker more subject to it than anything else." He observed platform crewmembers might be less sensitive to job stress because they are regularly and frequently off-work. (EX-4, pp. 19-20).

Dr. O'Meallie noted that the defibrillators in use when Decedent died were "not in general use." Modern automatic defibrillators and associated training programs were likewise unavailable when Decedent died. Dr. O'Meallie generally agreed with Dr. Simon that approximately two-thirds of patients experiencing complications from heart disease die before they

reach the hospital. He also agreed with Dr. Simon that the mortality rate of ventricular fibrillation outside of hospitals is approximately 95 percent. In light of the statistics, Dr. O'Meallie opined Decedent's death "had nothing to do with the lack of a defibrillator." (EX-4, pp. 21-22).

Dr. O'Meallie noted Decedent continued smoking cigars after a 40-year history of smoking cigarettes before his first coronary event. Decedent's ongoing cigar smoking was "absolutely" a risk factor in his coronary condition. "Without a doubt," it is "just as likely" that Decedent's death could have occurred at home. Dr. O'Meallie found no evidence implying Decedent's "work caused his death any more so than any factor that could have arisen in his home." (EX-4, pp. 22-23).

On cross-examination, Dr. O'Meallie indicated he testified for the defense in the last four civil matters in which he was an expert, but he has testified for both plaintiffs and defendants. His office does not provide medical treatment under any health plan for Employer's employees. (EX-4, pp. 24-26).

Dr. O'Meallie indicated NIH is a recognized coronary disease information source for the general public. He was aware NIH published heart attack survival plans but had not reviewed such a plan. He generally agreed with NIH that quicker medical treatment increases the likelihood of heart attack survival. He generally agreed with Dr. Simon's statistics regarding survival rates from ventricular fibrillation, and noted the "outcomes are pretty poor." (EX-4, pp. 26-29).

Dr. O'Meallie agreed with Dr. Simon that defibrillators are valuable and necessary, but disagreed that defibrillators are always necessary to abort cardiac arrests, noting that CPR occasionally restarts hearts. With CPR, the survival rate among fibrillating patients is "in the single digits." With defibrillators, the success rate is between 85 or 95 percent if defibrillation is "instantaneous," or within thirty seconds. However, if fibrillation continues for three or four minutes before defibrillation, it is "very difficult to get the patient out of it," and the patient will likely sustain significant brain impairment. (EX-4, pp. 29-32).

Dr. O'Meallie added that the "underlying substrate" causing fibrillation is "vital," because the situation may "continue to evolve. The ventricular fibrillation is not a stand-alone illness. It's a complication of underlying factors going on simultaneously in the heart muscle." Consequently,

defibrillation, which might briefly provide a result, becomes "irrelevant" if the underlying process causing fibrillation is not remedied. He conceded that successful defibrillation is generally accepted as living "a little longer," although a patient soon dies from the underlying substrate which caused the initial ventricular fibrillation. (EX-4, pp. 32-34).

Dr. O'Meallie indicated cigar smoking is approximately the same health risk as cigarette smoking. Dr. O'Meallie doubted claims that cigar smoke is rarely inhaled and noted that cigar smoke "still pollute[s] your atmosphere and some of the components are absorbed." He agreed the circumstances causing Decedent's death are speculative; however, he explained his hypothesis that Decedent suffered a cardiac event related to acute coronary syndrome either with or without myocardial infarction terminating in ventricular fibrillation and sudden death was consistent with Dr. Simon's theory. He opined the timeframe between the onset of symptoms and death can be "minutes or it can be hours." (EX-4, pp. 34-35).

Other Evidence

Mr. Marshall Satterwhite

A transcript of an undated conversation with Mr. Satterwhite reveals Mr. Satterwhite was a cook aboard the production platform with Decedent, Larry Fortenberry, Gary Priddy and Bill Teel on October 5, 1998. At approximately 1:50 a.m., Mr. Satterwhite was awakened in his room when Decedent called over the platform intercom system requesting Mr. Fortenberry's assistance. Mr. Satterwhite got out of bed to check on Mr. Fortenberry after Decedent again requested Mr. Fortenberry's help via the intercom. As Mr. Satterwhite was exiting his room, the general alarm sounded, and he "ran down the hall and woke everybody up." Except for Decedent's bedroom, which was on a lower level near the platform office, all of the bedrooms were on an upper level. (CX-16, pp. 1-4, 7-8).

Around 2:00 a.m., after all of the crewmembers were awake, everybody went downstairs to Decedent's room, where Decedent was leaning back in a chair sweating profusely. Mr. Teel, who was the "first responder," loosened Decedent's overalls and attempted to make him more comfortable. Decedent, who had taken a nitroglycerin pill, was complaining of severe chest pain. Mr. Teel provided two more nitroglycerin tablets and directed the crewmembers to find washcloths and emergency oxygen. Blankets were placed on the floor, where Decedent "stretched out." The

crewmembers provided the oxygen to Decedent and watched his vital signs as he continued complaining of chest pain. (CX-16, pp. 8-10, 12).

Around 2:10. a.m., Mr. Fortenberry called for a helicopter while the crew attended to Decedent. There were no local "night flights . . . that came offshore." A helicopter out of Sabine Pass, Texas, was dispatched with a 4:10 a.m. estimated time of arrival. Mr. Satterwhite noted the production platform was nine miles from the Texas barrier islands, "about 20 miles from heliport." (CX-16, pp. 3, 9-10).

Meanwhile, Decedent's condition worsened. His breathing stopped at 2:45 a.m., when he "started gasping real bad and . . . losing his pulse." Mr. Teel and Mr. Fortenberry provided CPR for "about 40 minutes" until Mr. Satterwhite and Mr. Priddy relieved them to continue providing CPR for another 20 minutes. According to Mr. Satterwhite, who noted vital signs were never regained after CPR began, Decedent probably died "not too long after CPR was started on him." (CX-16, p. 10).

Around 3:45 a.m., the crew was notified that the helicopter was going to be approximately 20 minutes late. Although there was no rain or fog impeding travel, a strong head wind was problematic. At that time, CPR was discontinued after Decedent remained unresponsive. The helicopter arrived at 4:30 a.m., twenty minutes beyond its estimated time of arrival. Decedent was placed onto a stretcher aboard the aircraft. Mr. Teel and Mr. Fortenberry accompanied Decedent to the hospital, where he was pronounced dead on arrival. Mr. Satterwhite opined Mr. Fortenberry "did everything he could to get a helicopter as quick [sic] as possible. Everything that could be done for [Decedent] in my opinion was done." (CX-16, pp. 10-11, 16).

Mr. Satterwhite knew Decedent for approximately two years prior to October 5, 1998. Decedent, whose office was next to the galley, regularly talked to Mr. Satterwhite. They generally discussed family life and hobbies. Decedent enjoyed being with his family and his granddaughter and he also enjoyed gardening at home when he was off-duty. When Decedent needed to rest, he often requested Mr. Satterwhite to "catch the phones for him." (CX-16, pp. 4-6).

Mr. Satterwhite recalled Decedent had a history of heart complaints, including an incident on a drilling platform during the fall of 1997, when he ultimately underwent an angioplasty procedure. Following his angioplasty, Decedent returned to

work. He "stayed pretty much in the office, answered his phones, did his paperwork [and] did not go outside much." He continued smoking cigars, although he entirely discontinued smoking cigarettes. After Decedent underwent another angioplasty in March or April 1998, Mr. Satterwhite recalled Decedent was occasionally tired and needed to rest, but there were no "major" complaints involving chest pain. Decedent "watched himself pretty closely. He wouldn't run up and down the stairs, he would ease up them and really tried not to push himself . . . ." (CX-16, pp. 4-5, 13-15).

Since Mr. Satterwhite began working with Employer in 1996, Decedent always "watched his diet very carefully . . . and probably maintained his diet as well as or if not better than most people out here [sic]." On Saturday, October 3, 1998, Decedent weighed approximately 193 to 194 pounds when he weighed himself. He remarked he "gained a couple of pounds," and ate cereal and fruit on Sunday morning, October 4, 1998. Decedent's weight was reported as 190 pounds when he was placed aboard the helicopter on October 5, 1998. (CX-16, pp. 4-5, 14-15).

According to Mr. Satterwhite, Decedent was a field foreman who managed three manned platforms and one unmanned platform. His duties included of "managerial type duties," including troubleshooting and paperwork. He was not required to perform strenuous tasks. He typically worked 12-hour days like anyone else aboard the platform; however, there was no nightly relief foreman. If an emergency occurred on one of the other platforms, Decedent was available by telephone. Such emergencies did not often occur. (CX-17, pp. 6-7, 16).

Mr. Satterwhite described Sunday, October 4, 1998, as a "quiet day." He observed Decedent perform "nothing strenuous at all." While Decedent usually traveled to other platforms on Sundays, rain and weather on October 4, 1998, precluded his visits to the other platforms. Consequently, Decedent was "pretty much around the office all day with very few phone calls. There was nothing strenuous going on that day." (CX-16, pp. 11-12).

Mr. Larry Fortenberry

On January 4, 2000, Mr. Fortenberry, who was Decedent's supervisor, provided a recorded statement. On October 5, 1998, Decedent used an intercom system to request help from the other crewmembers around 2:00 a.m. Mr. Teel reached Decedent first and provided a blood pressure monitor and nitroglycerin.

Decedent was in a chair attempting to rise, but the crew arranged an area for him to lie down and relax on the floor. Decedent told Mr. Teel he had taken some aspirin before going to bed. Mr. Fortenberry noted, "it was almost instantaneous, [Decedent] was just starting to have [what] looked like a massive heart attack." (CX-15, pp. 1-6, 9).

At approximately 2:10 a.m., Mr. Fortenberry called for a "night flight" helicopter to transport Decedent to a hospital. He did "not have access to a Coast Guard type helicopter at that time," but was able to secure a large helicopter out of Sabine Pass, Texas. He noted Employer's platform was nearly 18 miles from shore. (CX-15, pp. 3, 6-7).

Despite their help, the crew "could tell we were losing [Decedent]." Mr. Fortenberry and Mr. Teel administered CPR when Decedent quit breathing around 2:10 a.m. Mr. Fortenberry opined Decedent did not "last long" after CPR was begun. Nevertheless, CPR was continued for roughly one hour until it was apparent to the entire crew that Decedent was unresponsive. (CX-15, pp. 5-7).

Meanwhile, the helicopter, which had trouble with high winds, arrived at approximately "a little bit after 4:00 a.m." Mr. Fortenberry and Mr. Teel accompanied Decedent on the helicopter to the hospital, where decedent was immediately taken to an emergency cardiac facility. He was pronounced dead on arrival. (CX-15, pp. 7-8).

Mr. Fortenberry knew Decedent "off and on since 1985." Mr. Fortenberry was Decedent's supervisor for nearly one year prior to October 5, 1998. Mr. Fortenberry remembered Decedent began complaining of heart problems around "the early part of 1998," when stents were inserted. Decedent never related his heart problems to work. Rather, he "blamed it on his lifestyle," which included a 40-year history of smoking. He changed his diet to "a real low cholesterol type of diet that the doctor put him on" and quit smoking cigarettes, although he continued using cigars. (CX-15, pp. 2-4).

Mr. Fortenberry recalled nothing "out of the ordinary" during the day on October 4, 1998. He and Decedent visited another platform, where "it was kind of a strenuous ordeal just going up to the helicopter. [Decedent] didn't act like he felt too good to me at the time." After they left the platform, Decedent "felt good, so . . . he never brought anything up." Mr. Fortenberry watched football in the evening with Decedent

until Decedent went to bed. Mr. Fortenberry could not remember what Decedent ate for dinner before the heart attack. He remembered Mr. Teel discussing Decedent smoked "part of a cigar" that evening. (CX-15, pp. 9-11).

Mr. Gary Priddy

On January 10, 2000, Mr. Priddy, who was an electrician aboard the platform when Decedent died, provided a recorded statement. On October 5, 1998, the platform emergency alarm sounded at around 2:00 a.m. Mr. Priddy went downstairs to Decedent's room, where Mr. Fortenberry, Mr. Satterwhite and Mr. Teel also arrived to find Decedent in a chair apparently suffering from a heart attack. Decedent was placed on the floor, and Mr. Fortenberry started working on helicopter transportation immediately. (CX-14, pp. 1-6, 10-11).

According to Mr. Priddy, Mr. Teel directed Mr. Satterwhite to find some nitroglycerin and oxygen, which were provided to Decedent at approximately 2:10 a.m. Decedent remained on oxygen for nearly 30 minutes until his heart stopped beating. CPR was begun by Mr. Teel and Mr. Fortenberry around 2:30 a.m. or 2:45 a.m. CPR was continued by the crew for nearly 1.5 hours, but Decedent remained unresponsive. (CX-14, pp. 6-7, 12-13).

The helicopter which was requested by Mr. Fortenberry arrived around 4:30 a.m. or 4:45 a.m. Decedent was immediately transported to a hospital onshore, where he was pronounced dead on arrival. Mr. Priddy understood "by word of mouth" that Decedent suffered "a fatal heart attack." (CX-14, pp. 7-8).

Mr. Priddy worked with Decedent for approximately five years before his death. Around the end of 1997 or the beginning of 1998, Decedent complained of chest pains and shortness of breath which warranted medical treatment and multiple stent insertions. He returned for treatment nearly three months later when problems with the stents arose. He "tried to watch what he ate" before he received stents, but modified his diet to reduce fat and cholesterol after he underwent the surgery. After he received stents, Decedent quit smoking cigarettes but continued smoking cigars "once in a while." Mr. Priddy recalled that Decedent enjoyed being with his family and working around the house. (CX-14, pp. 3, 8-9).

On the Sunday before Decedent's death, Mr. Priddy was unaware of any activities which were "out of the ordinary" for Decedent, who complained of no chest pains. When Mr. Priddy

went to bed before Decedent's heart attack, he observed Decedent watching television with Mr. Fortenberry. Decedent "looked [like] just normal old Larry to me." (CX-14, p. 9).

According to Mr. Priddy, nobody "in the field was aware the Coast Guard would come out in a situation like this." He noted another worker, "Glenn Kitchens," needed to be evacuated at night from the platform during the week before Decedent's fatal heart attack. Mr. Kitchens's helicopter transportation took a long time. Mr. Priddy recalled Mr. Teel researched USCG service "after the fact" and determined the USCG could have provided helicopter transportation which would have taken approximately one hour to arrive at the platform. (CX-14, pp. 9-11).

In Decedent's case, Mr. Priddy, who estimated Decedent died without the use of defibrillators around 2:40 a.m. or 2:45 a.m., estimated the USCG, who might have provided defibrillators, would have arrived shortly after 3:00 a.m. Employer opted to use a private helicopter service which provided no defibrillators. Mr. Priddy thought Mr. Teel was an emergency medical technician who was qualified and trained to use defibrillators.

On June 27, 2003, Mr. Priddy signed a statement apparently sent to him from Claimants' attorney's law firm by electronic mail presumably based on Mr. Priddy's recollection of the facts surrounding the instant matter. (CX-13).

Mr. Priddy estimated there were "between 8 and 10" employees located on three different platforms who were "in my crew and under [Decedent's] supervision." Additionally, Decedent supervised independent contractors on location at the platforms. Mr. Priddy indicated the crew, including Decedent, worked from 6:00 a.m. through 6:30 p.m. on October 4, 1998. The crew was also required to be "available 24 hours a day for emergencies." He recalled the crew was "required to eat, sleep and live on the rig when not working." (CX-13, p. 1).

Mr. Priddy noted the platform where Decedent died was approximately 40 miles from Corpus Christi, Texas, 20 miles from Rockport, Texas, and 11 miles directly off the Texas coast. The USCG is stationed in Corpus Christi, where Mr. Priddy, who was familiar with the Corpus Christi USCG station because he lived nearby it, was aware the USCG provided rescue helicopters. Id.

Mr. Priddy speculated Decedent could have been helped through the use of "electric shock defibrillator paddles seen on

television." Prior to October 5, 1998, "the topic of these paddles had come up on a number of occasions," but Employer refused to provide defibrillators on offshore platforms because of the costs associated with purchasing the devices and training employees to use them as well as "the possible liability if the machines were used incorrectly." Mr. Priddy reported Mr. Teel was "trained in the use of the electric paddles and would have used them on [Decedent] had they been available." (CX-13, pp. 1-2).

Mr. Priddy indicated the crew was "under the impression that we could not contact the Coast Guard to have [Decedent] evacuated, even though he appeared to be having a heart attack." Later, however, Mr. Priddy recalled Mr. Teel contacted the USCG, which indicated it would provide emergency services at Employer's expense. The USCG would not allow extra passengers, but Employer's policy required supervisors to accompany injured employees ashore. According to Mr. Priddy, "Eugene Leal" suffered a "heart attack during the daytime hours." Decedent accompanied Mr. Leal to shore on a helicopter which made an interim stop at another platform to pick up a supervisor. (CX-13, p. 2).

Mr. Priddy opined Decedent, who would have preferred tool work to management work, was "constantly stressed out about his work." He described Decedent's job as "much more stressful than a field hand." He indicated previous emergencies, including an oil spill and a co-worker's heart attack requiring Decedent to travel to shore on a helicopter, exacerbated Decedent's stress earlier in the week before his death. Mr. Priddy added that Mr. Fortenberry's presence aboard the platform was unusual and added to Decedent's stress. He noted Decedent traveled to another platform and likely climbed several flights of stairs with Mr. Fortenberry on October 4, 1998. In consideration of Decedent's presence aboard both platforms, Mr. Priddy estimated Decedent climbed a total of eight to 22 flights of stairs on October 4, 1998. Id.

Mr. Priddy reported, "While working on an offshore oilrig, because you have co-workers around you, you do not feel isolated." However, he opined everybody on the platform felt "very isolated" when Decedent died "because it took so long for the helicopter to come take [Decedent] to the hospital." (CX-13, pp. 2-3).

Mr. Bill Teel

Mr. Teel provided an undated report indicating he had roughly 22.5 years of experience with Employer and was a technician mechanic aboard the platform when Decedent died. He knew Decedent for nearly five years. (EX-4).

According to Mr. Teel's report, Decedent appeared overweight aboard the platform, where he smoked a cigar nightly. He either observed Decedent smoking the cigar or smelled the smoke in the living quarters. Decedent's room, which was directly across a hall from the galley and exercise equipment, was equipped with a private bath which made it unnecessary to climb stairs daily to rest and bathe. Id.

Mr. Teel indicated the platform had an exercise bicycle available for all employees, while the helicopter pad was also available for walking exercises. Employer's policy provided for special dietary needs, including heart-healthy requirements, to be accommodated by a "simple request to the cook." Id.

Mr. Teel reported Decedent's job as a field foreman was "not especially stressful." Decedent managed and oversaw the activities of two teams and most of his work was performed on a computer in an office. Although the alarms occasionally occurred, "it was extremely rare to have an alarm of any serious nature." Mr. Teel recalled no serious alarms or emergencies during Decedent's last hitch.[4] Id.

Mr. Teel noted Decedent was not required to climb stairs quickly, nor was he required to carry tools. Because Decedent's job was administrative rather than technical, he "could take his time and rest after climbing a flight of stairs." Mr. Teel estimated Decedent was accustomed to his physical and mental job requirements in light of his offshore platform history. According to Mr. Teel, Decedent's supervisor, Mr. Fortenberry, was on the platform at the time of Decedent's death; however, Mr. Fortenberry, who "worked very well with the people who reported to him," often visited the platform. His presence aboard the platform should not have caused Decedent much stress. Likewise, Decedent's "routine" trip with Mr. Fortenberry to another platform prior to Decedent's death should not have caused any particular stress. Mr. Teel could not recall

[4] Mr. Teel did not report a co-worker's alleged heart attack which required Decedent to accompany the worker to shore for treatment. (EX-4).

Decedent objecting to any work as too difficult during the day he died. Id.

Decedent's Death Certificate

On October 5, 1998, Decedent died from natural causes due to atherosclerotic coronary artery disease, according to the medical examiner, Floyd White, M.D., Ph.D. (CX-26; CX-28, pp. 14-15).

Claimants' Internet Exhibits

According to NIH publications, which were apparently accessed via the Internet on August 27, 2003, heart attack warning signs, including discomfort in the chest, arms, jaw, back, neck or stomach, cold sweat, nausea or light-headedness, must be understood and promptly acted upon as part of a "heart attack survival plan." A "NIH News Release" indicates one in five patients arrives at a hospital soon enough to benefit from medical treatments. The NIH documents indicate factors which increase the risk of heart attacks include: (1) a previous heart attack or angina; (2) family history; (3) diabetes; (4) high blood cholesterol; (5) high blood pressure; (6) cigarette smoking; (7) being overweight; and (8) physical inactivity. According to the publication, "delay can be deadly." (CX-17, pp. 1-8, 19).

According to an excerpt of an Internet publication which was apparently accessed on January 15, 2003, and which was written by "Cathryn Conroy," a "Netscape News Editor," whose credentials are not of record, "CNN's Dr. Sanjay Gupta," whose credentials are also not of record, reported "researchers followed 800 employees in Finland for a full 30 years and concluded that those who had stressful jobs had twice the risk of dying from heart disease than those who had satisfying jobs." Stress was apparently defined as "an extremely demanding job with high-productivity requirements but having little control or reward in return." Dr. Gupta advised, "If this sounds like your job, it's time for a change." Knight-Ridder Newspapers reported dreaming about jobs is an indication "you might be stressed at work." (CX-29, p. 58).

According to an "Advocate Health Care" Internet publication which was apparently accessed on November 5, 1999, heart and blood vessel diseases are associated with risk factors, which are specific conditions or behaviors. Some risk factors may be controlled, while others may not be changed. Controllable risk

factors include smoking, high blood pressure, blood cholesterol levels and stress. Heredity, gender and age are risk factors which may not be altered, while obesity, lack of exercise and diabetes are identified as "contributing factors." According to Dr. Hans Seyle, whose credentials are not of record, "stress" is a "non-specific response of the body to any demand made upon it." Stress, which "is defined by perception," may or may not trigger physiological responses, including increased blood pressure and an increased rate of breathing. Stress management is a "learning process" in which individuals must: (1) identify causes of stress; (2) take steps to avoid stress; and (3) re-learn methods of coping with stress. (CX-29, pp. 59-65).

USCG Documents

The USCG provided various data including: (1) a map indicating the geographical region served by its helicopters in the Corpus Christi, Texas, region; (2) hand-written distress logs indicating various emergencies; (3) an Aircraft Status Report indicating two helicopters were available on October 4 and 5, 1998; (4) a "Standard Operating Procedure" document indicating "in the case of a reported heart attack victim, the aircrew is launched immediately" and a "flight surgeon is also consulted to determine the necessity of aerial or surface medevac;" (5) a copy of the USCG procedure for cost recovery and reimbursement indicating the USCG does not generally assert search and rescue costs against benefactors. The information does not indicate whether defibrillators were available on October 4 and 5, 1998. (CX-20).

The Contentions of the Parties

Claimants argue they are entitled to death benefits under the Act because Decedent's physical and mental job stresses precipitated his October 5, 1998 heart attack aboard an offshore platform. They also argue that, had Employer attempted to evacuate Decedent from the rig with help from the USCG in Corpus Christi, Texas, which is approximately 20 minutes away by helicopter from the platform, medical care could have been provided by the USCG while transporting the Claimant. Instead, Employer contracted with a private helicopter service which had no medical capabilities and which was located in Sabine Pass, Texas, approximately 180 miles away from the rig. The private helicopter, which took two to three hours to reach the rig due to a strong headwind, failed to reach Decedent before his expiration.

Moreover, Claimants argue Employer failed to provide emergency medical care to Decedent because there was no defibrillator on the rig. They contend Decedent would have survived longer with such a device aboard the rig.

Employer/Carrier argue that Decedent suffered from a pre-existing condition of coronary artery disease, which was not occupationally related. They contend that onboard defibrillators were not available in 1998 when Decedent suffered his heart attack.

IV. DISCUSSION

A. Evidentiary Rulings

The parties did not object to the admission of hearsay statements provided by Decedent's co-workers. The statements were relied upon by the record physicians to render medical opinions and relied upon by the parties in their post-hearing briefs. Accordingly, without objection, I find no reason to depart from the decision to receive those exhibits at the hearing.

Employer/Carrier object to Claimants' Internet evidence, identified as CX-23 and exhibit evidence to CX-29. The evidence was discussed by the record physicians in their deposition testimony. Insofar as the evidence, which is notably of questionable reliability, was considered by the physicians in rendering opinions, I find the evidence is relevant and shall be received as CX-23 and exhibit evidence to CX-29.

Employer/Carrier also object to Claimants' introduction of USCG information identified as CX-20. Although I agree with Employer/Carrier that the evidence is of questionable relevance and reliability, I receive the evidence as CX-20 for completeness of the record.

It has been consistently held that the Act must be construed liberally in favor of the Claimant. Voris v. Eikel, 346 U.S. 328, 333 (1953); J. B. Vozzolo, Inc. v. Britton, 377 F.2d 144 (D.C. Cir. 1967). However, the United States Supreme Court has determined that the "true-doubt" rule, which resolves factual doubt in favor of the Claimant when the evidence is evenly balanced, violates Section 7(c) of the Administrative Procedure Act, 5 U.S.C. Section 556(d), which specifies that the proponent of a rule or position has the burden of proof and, thus, the burden of persuasion. Director, OWCP v. Greenwich

Collieries, 512 U.S. 267, 114 S.Ct. 2251 (1994), aff'g. 990 F.2d 730 (3rd Cir. 1993).

In arriving at a decision in this matter, it is well-settled that the finder of fact is entitled to determine the credibility of witnesses, to weigh the evidence and draw his own inferences therefrom, and is not bound to accept the opinion or theory of any particular medical examiners. Duhagon v. Metropolitan Stevedore Company, 31 BRBS 98, 101 (1997); Avondale Shipyards, Inc. v. Kennel, 914 F.2d 88, 91 (5th Cir. 1988); Atlantic Marine, Inc. and Hartford Accident & Indemnity Co. v. Bruce, 551 F.2d 898, 900 (5th Cir. 1981); Bank v. Chicago Grain Trimmers Association, Inc., 390 U.S. 459, 467, reh'g denied, 391 U.S. 929 (1968).

B. The Compensable Injury

Section 2(2) of the Act defines "injury" as "accidental injury or death arising out of or in the course of employment." 33 U.S.C. § 902(2). Section 20(a) of the Act provides a presumption that aids the Claimant in establishing that a harm constitutes a compensable injury under the Act. Section 20(a) of the Act provides in pertinent part:

> In any proceeding for the enforcement of a claim for compensation under this Act it shall be presumed, in the absence of substantial evidence to the contrary-that the claim comes within the provisions of this Act.

33 U.S.C. § 920(a).

The Benefits Review Board (herein the Board) has explained that a claimant need not affirmatively establish a causal connection between his work and the harm he has suffered, but rather need only show that: (1) he sustained physical harm or pain, and (2) an accident occurred in the course of employment, or conditions existed at work, which **could have caused** the harm or pain. Kelaita v. Triple A Machine Shop, 13 BRBS 326 (1981), aff'd sub nom. Kelaita v. Director, OWCP, 799 F.2d 1308 (9th Cir. 1986); Merrill v. Todd Pacific Shipyards Corp., 25 BRBS 140 (1991); Stevens v. Tacoma Boat Building Co., 23 BRBS 191 (1990). These two elements establish a **prima facie** case of a compensable "injury" supporting a claim for compensation. Id.

1. Claimants' Prima Facie Case

Claimants contend Decedent's death was an accidental injury or death arising out of or in the course of his employment aboard an offshore platform. Employer/Carrier, who concede in their brief that Decedent suffered a heart attack "at work," contend his death was the result of his underlying coronary artery disease and otherwise unrelated to his occupation.

A claimant's **credible** subjective complaints of symptoms and pain can be sufficient to establish the element of physical harm necessary for a **prima facie** case and the invocation of the Section 20(a) presumption. See Sylvester v. Bethlehem Steel Corp., 14 BRBS 234, 236 (1981), aff'd sub nom. Sylvester v. Director, OWCP, 681 F.2d 359, 14 BRBS 984 (CRT)(5th Cir. 1982).

In the present matter, it is plausible Decedent suffered a heart attack related to the conditions of his employment. Mrs. Chauvin credibly testified Decedent was in his current occupation when he originally suffered from symptoms which required the implantation of arterial stents. Likewise, she testified Decedent experienced physical and emotional job stresses, including stair-climbing and employee management, which Drs. Baker, Simon and O'Meallie generally agreed might, under certain circumstances, raise adrenaline levels to increase blood pressure and cause cardiac symptoms.

Thus, Claimants have established a **prima facie** case that Decedent suffered an "injury" under the Act, having established that he suffered a harm or pain on October 5, 1998, and that his working conditions and activities during the preceding hours on October 4, 1998 could have caused the harm or pain for causation sufficient to invoke the Section 20(a) presumption. Cairns v. Matson Terminals, Inc., 21 BRBS 252 (1988).

2. Employer's Rebuttal Evidence

Once Claimants' **prima facie** case is established, a presumption is invoked under Section 20(a) that supplies the causal nexus between the physical harm or pain and the working conditions which could have cause them.

The burden shifts to the employer to rebut the presumption with substantial evidence to the contrary that Decedent's condition was neither caused by his working conditions nor aggravated, accelerated or rendered symptomatic by such conditions. See Conoco, Inc. v. Director, OWCP [Prewitt], 194

F.3d 684, 33 BRBS 187 (CRT)(5th Cir. 1999); Gooden v. Director, OWCP, 135 F.3d 1066, 32 BRBS 59 (CRT)(5th Cir. 1998); Louisiana Ins. Guar. Ass'n v. Bunol, 211 F.3d 294, 34 BRBS 29(CRT)(5th Cir. 1999); Lennon v. Waterfront Transport, 20 F.3d 658, 28 BRBS 22 (CRT)(5th Cir. 1994);. "Substantial evidence" means evidence that reasonable minds might accept as adequate to support a conclusion. Avondale Industries v. Pulliam, 137 F.3d 326, 328 (5th Cir. 1998); Ortco Contractors, Inc. v. Charpentier, 332 F.3d 283 (5th Cir. 2003) (the evidentiary standard necessary to rebut the presumption under Section 20(a) of the Act is "less demanding than the ordinary civil requirement that a party prove a fact by a preponderance of evidence").

Employer must produce facts, not speculation, to overcome the presumption of compensability. Reliance on mere hypothetical probabilities in rejecting a claim is contrary to the presumption created by Section 20(a). See Smith v. Sealand Terminal, 14 BRBS 844 (1982). The testimony of a physician that no relationship exists between an injury and a claimant's employment is sufficient to rebut the presumption. See Kier v. Bethlehem Steel Corp., 16 BRBS 128 (1984).

When aggravation of or contribution to a pre-existing condition is alleged, the presumption still applies, and in order to rebut it, Employer must establish that Decedent's work events neither directly caused the injury nor aggravated the pre-existing condition resulting in injury or pain. Rajotte v. General Dynamics Corp., 18 BRBS 85 (1986). A statutory employer is liable for consequences of a work-related injury which aggravates a pre-existing condition. See Bludworth Shipyard, Inc. v. Lira, 700 F.2d 1046 (5th Cir. 1983); Fulks v. Avondale Shipyards, Inc., 637 F.2d 1008, 1012 (5th Cir. 1981). Although a pre-existing condition does not constitute an injury, aggravation of a pre-existing condition does. Volpe v. Northeast Marine Terminals, 671 F.2d 697, 701 (2d Cir. 1982). It has been repeatedly stated employers accept their employees with the frailties which predispose them to bodily hurt. J. B. Vozzolo, Inc. v. Britton, supra, 377 F.2d at 147-148.

If an administrative law judge finds that the Section 20(a) presumption is rebutted, he must weigh all of the evidence and resolve the causation issue based on the record as a whole. Universal Maritime Corp. v. Moore, 126 F.3d 256, 31 BRBS 119(CRT)(4th Cir. 1997); Hughes v. Bethlehem Steel Corp., 17 BRBS 153 (1985); Director, OWCP v. Greenwich Collieries, supra.

Employer/Carrier produced the opinions of Drs. Baker and O'Meallie that Decedent's job neither caused nor contributed to his fatal heart attack. Employer also submitted the statement of Decedent's co-worker, Mr. Teel, who generally indicated Decedent did not suffer from any job-related stress which precipitated his death. Accordingly, I find Employer/Carrier submitted evidence which tends to establish Decedent's job neither directly caused his coronary artery disease nor aggravated his pre-existing coronary artery disease resulting in his death, which warrants a review of the entire record for a resolution of the matter.

3. Weighing the Entire Record

As noted in a similar matter involving the determination of whether a heart attack was occupationally related, "The problem this case presents is not solely a medical one, but is compounded of inextricably mingled elements of fact, medical opinion, and inference." Todd Shipyards Corp. v. Donovan, 300 F.2d 741 (5th Cir. 1962)(the occurrence of a claimant's heart attack immediately following strenuous activities in itself raises an inference of a causal relationship between the activities and the attack). The instant record consists of three medical opinions coupled with the testimony of Decedent's wife and hearsay statements of co-workers. The record also includes other evidence, including Internet publications, which are of questionable probative value. I find the medical opinions, to the extent they are supported by the record, are dispositive of the issues presented herein.

a. Decedent's Heart Attack and the Conditions of His Employment

Prefatorily, the opinion of a treating physician may be entitled to greater weight than the opinion of a non-treating physician. Black & Decker Disability Plan v. Nord, 123 S.Ct. 1965, 1970 n. 3 (2003) (in matters under the Act, courts have approved adherence to a rule similar to the Social Security treating physician rule in which the opinions of treating physicians are accorded special deference) (citing Pietrunti v. Director, OWCP, 119 F.3d 1035 (2d Cir. 1997) (an administrative law judge is bound by the expert opinion of a treating physician as to the existence of a disability "unless contradicted by substantial evidence to the contrary")); Rivera v. Harris, 623 F.2d 212, 216 (2d Cir. 1980) ("opinions of treating physicians are entitled to considerable weight"); Loza v. Apfel, 219 F.3d 378, 393 (5th Cir. 2000) (in a Social Security matter, the Court

noted that a treating physician's medically supported opinion as to the existence of a disability is binding on the fact-finder unless contradicted by substantial evidence to the contrary).

Of the record medical opinions, I find the opinions of Decedent's treating physician, Dr. Baker, who treated Decedent and performed the multiple surgeries in this matter, are more persuasive, well-reasoned and supported by the record. Dr. Baker's opinion that Decedent suffered from pre-existing coronary artery disease, which is related to non-occupational risks such as family history, cigarette smoking, and elevated cholesterol, is consistent with the opinions of Drs. Simon and O'Meallie. His opinion that Decedent's condition is unrelated to his job is consistent with Dr. Simon's opinion that Decedent's job did not "per se" result in coronary artery disease risk factors. Dr. Baker's opinion is likewise supported by Dr. O'Meallie's opinion that Decedent's condition was not related to his job.

Likewise, Dr. Baker's opinion that Decedent experienced symptoms related to restenosis due to scar tissue surrounding the insertion of arterial stents is consistent the opinions of Drs. Simon and O'Meallie. Dr. Baker's opinion that restenosis is not work-related is consistent with Dr. Simon's opinion that restenosis is the result of disease intervention rather than a work-related condition. Likewise, Dr. Baker's opinion is supported by Dr. O'Meallie's opinion that restenosis is a condition involving arterial occlusion due to scar tissue which forms after the insertion of stents. Moreover, I find Dr. Baker's uncontroverted opinion that restenosis is not indicative of individuals who are more likely to experience increased coronary complaints is persuasive. Accordingly, I find Decedent suffered from pre-existing coronary artery disease and restenosis which were not occupationally related.

I find Dr. Baker's opinion that Decedent's occupation caused no heart damage prior to the instant heart attack is persuasive and supported by Dr. Simon's opinion that Decedent's prior heart complaints caused no muscle damage prior to the October 5, 1998 heart attack, which was Decedent's first heart attack. Likewise, I find Dr. Baker's opinions that Decedent's underlying coronary artery disease involved multiple risk factors increasing the likelihood of reoccurrence and that the malady is generally chronic without "dramatic lifestyle changes" is consistent with Dr. Simon's opinion that the progression of Decedent's disease involved non-occupational factors, including tobacco use, Decedent's genetic structure and other risks which

were Decedent's "personal responsibility." Dr. Baker's opinion is equally supported by Dr. O'Meallie's opinion that Decedent was positive for multiple risk factors including increased weight and continued tobacco use, which were not occupationally related.

Similarly, I find Dr. Baker's opinion that heart attacks such as Decedent's are unrelated to activity is consistent with Dr. O'Meallie's opinion that Decedent suffered a sudden cardiac arrest which had "nothing to do" with employment. Dr. Baker's opinion that heart attacks such as Decedent's occur from the natural development of coronary artery disease is supported by Dr. Simon's opinion that the manifestations of coronary artery disease include angina, myocardial infarction and cardiac arrest. His opinion is likewise supported by Dr. Simon's opinion that Decedent could have sustained his heart attack at home.

Claimants contend Dr. O'Meallie's medical opinions should be discounted because they are devoted to Decedent's "fault" in the instant matter; however I disagree. While I agree that Section 4(b) of the Act provides compensation shall be payable irrespective of fault, I find Dr. O'Meallie's testimony generally addressed the progression of Decedent's disease in light of ongoing multiple risk factors which are not occupationally related. Insofar as all the physicians agree non-occupational risks are associated with the progression of coronary artery disease, which Dr. Simon even conceded are Decedent's "personal responsibility," I find Dr. O'Meallie's opinions are relevant and probative for a resolution of the matter. Moreover, Claimants' evidence, namely the statement of Mr. Fortenberry, indicates Decedent related his condition to "his lifestyle." In light of the foregoing, I am inclined to find Decedent's heart attack was not occupationally related.

Of the three physicians, Dr. Simon, who agreed Decedent's condition was eventually fatal due to non-occupational risks, stands alone in his opinion that Decedent's job contributed to or aggravated his underlying coronary artery disease to cause the fatal heart attack. However, I find his opinion equivocal in consideration of his opinion elsewhere that Decedent probably died from complications of restenosis, which caused myocardial infarction and was not occupationally related. Moreover, I find his opinions, which are generally based on facts not established in the record, were not as well-reasoned nor as factually supported as the opinions of Drs. Baker and O'Meallie, who agree

Decedent's job was unrelated to the eventual occurrence of his fatal heart attack.

Dr. Simon opined Decedent experienced physical stresses from climbing stairs which aggravated his underlying coronary artery disease. However, he conceded such activity, which is partially aerobic, may have been of healthful benefit if Decedent "could have had breaks going between stairs and didn't have to rush up the stairs." His concession is supported by Dr. O'Meallie's opinion that climbing stairs could be part of a "heart workout" and by Dr. Baker's opinions that exercise would not damage Decedent's heart and that Decedent's stair climbing did not cause Decedent's heart attack, unless perhaps Decedent was "running up and down the stairs several hours prior to going to sleep." Mr. Satterwhite's statement clearly indicates Decedent, who was not required to carry equipment, "wouldn't run up and down the stairs, he would ease up them and really tried not to push himself." Mr. Satterwhite's statement is supported by Mr. Teel's statement that Decedent "could take his time and rest after climbing a flight of stairs."

Although Mr. Fortenberry noted Decedent did not look like he felt well after climbing stairs on October 4, 1998, he reported Decedent "felt good" quickly thereafter and "never brought anything up." Mr. Fortenberry's statement is consistent with Mrs. Chauvin's testimony that Decedent complained of no symptoms related to work or climbing stairs during the evening before he died and with Mr. Teel's statement that Decedent did not object to any work as too difficult the day he died.

Mr. Fortenberry's statement is also consistent with Mr. Priddy's statement that Decedent's activities were "not out of the ordinary" on October 4, 1998, when he complained of no chest pains. Rather, Mr. Priddy's statement that Decedent looked "normal" before going to bed arguably indicates Decedent suffered no symptoms following his stair climbing on October 4, 1998. Likewise, Mr. Priddy's statement that Decedent was asymptomatic and looked normal before retiring for bed supports Dr. Baker's opinion that most patients would return to a "restful state within two hours following physical exertion." Accordingly, I find the record does not establish Decedent's stair climbing caused or contributed to his heart attack.

Dr. Simon's opinion that Decedent's psychological stresses on the job contributed to his heart attack are similarly unpersuasive. Dr. Simon unequivocally opined a psychologist would be more qualified to render psychological opinions;

however, as noted by Dr. Simon, the facts of this matter preclude such an opinion. Nevertheless, the record, to the extent the facts support psychological inferences, does not establish Decedent suffered any occupational psychological stresses which aggravated his underlying coronary artery condition to cause his heart attack.

Dr. Simon's opinion that Decedent suffered from ongoing multiple stresses related to his position in management is generally supported by Mrs. Chauvin's testimony that Decedent did not like his job because he did not like directing, evaluating and disciplining employees, and because of computer problems, voluminous paperwork which often required extended nightly activities, and ensuring compliance with environmental regulations. However, Mrs. Chauvin conceded Decedent did not complain about problems at work the night he died.

Likewise, the record does not establish the extent, if any, to which Decedent engaged in psychologically adverse managerial activities during his offshore stint prior to his heart attack, nor does the record establish the extent, if any, to which the alleged activities caused Decedent any stress before his death. Rather, the statements of Mr. Satterwhite, Mr. Fortenberry, Mr. Priddy and Mr. Teel indicate the day prior to Decedent's death was a "quiet day," in which Decedent engaged in no activities which were "out of the ordinary" and which otherwise should "not have caused any particular stress." Decedent apparently complained of no chest pains during the day, which concluded with watching television with his co-workers before he retired for bed after possibly smoking a cigar.

Mr. Priddy indicated Decedent was "constantly stressed" by his job, yet Mr. Priddy indicated Decedent's day prior to his death was not "out of the ordinary," as noted above. Further, Mr. Priddy's conclusion that Decedent complained of no symptoms and "looked like normal old Larry" when he last saw Decedent watching television with Mr. Fortenberry detracts from his statement that Decedent was "constantly stressed." Mr. Priddy's statement is also undermined by the statement of Mr. Teel, who indicated the events prior to Decedent's heart attack involved "routine" activities which should not have caused Decedent any stress. Likewise, Mr. Satterwhite's statement that Decedent was "pretty much around the office all day with very few phone calls" on a "quiet day" prior to his heart attack obscures Mr. Priddy's statement that Decedent was constantly stressed.

Although Mr. Priddy indicated an oil spill earlier in the week caused Decedent stress, the record inadequately supports his statement. Decedent's other co-workers described no such increased stress due to an oil spill, while Mrs. Chauvin conceded Decedent complained of no problems with work before he died. Likewise, Mr. Priddy's statement that Decedent accompanied another heart attack victim to shore is not described by the other co-workers. Notably, Mr. Priddy identified "Mr. Kitchens" as the apparent heart attack victim who required transportation at night; however, he later identified "Mr. Leal" as the heart attack victim who suffered his heart attack during the day, when he noted Decedent was required to make an additional stop to pick up a supervisor on the way to shore.

Further, his statement, which indicates Decedent accompanied the worker to shore on a private carrier which stopped along the way to pick up a supervisor, is inconsistent with Mrs. Chauvin's testimony that Decedent claimed he would call the USCG if a worker became ill on his watch. Without supporting testimony by Mrs. Chauvin or consistent statements from Decedent's co-workers, I find Mr. Priddy's statement fails to establish what stress, if any, occurred as a result of the alleged oil spill and medical treatment provided for the sick worker earlier in the week prior to Decedent's death.

Mr. Priddy's statement that Decedent suffered aggravated stress by the presence of Mr. Fortenberry aboard the platform is not supported by the statements of the other co-workers. Rather, Mr. Teel indicated the presence of Mr. Fortenberry, who "worked very well with the people who reported to him" and was often aboard the platform, would have caused Decedent no particular stress. Accordingly, I find Mr. Priddy's statement that Decedent suffered additional stress by the presence of his supervisor is not persuasive nor adequately factually supported.

On the other hand, Dr. O'Meallie, who, unlike Dr. Simon, has an extensive history treating offshore workers and is familiar with offshore platforms, opined Decedent should have been accustomed to the stressful demands of his job and was likely "experienced in handling stressful situations" after accumulating a five-year history of management and an overall offshore history of approximately 20 years. His opinion is supported by the statements of Mr. Teel, who indicated Decedent was accustomed to the physical and mental demands of his job, which should not have caused any particular stress, after years of experience.

Dr. Simon also stands alone in his opinion that loneliness aboard an offshore oilrig might contribute to a heart attack. His opinion is belied by Dr. O'Meallie's opinion that offshore workers do not feel isolated because they enjoy the "camaraderie" of offshore work with their co-workers. Dr. O'Meallie's opinion is supported by Mr. Priddy's statement that "while working on an offshore oilrig, because you have co-workers around you, you do not feel isolated." Accordingly, I find Dr. Simon's opinion that Decedent's alleged feelings of isolation contributed to his heart attack is not persuasive nor factually supported.

Moreover, Dr. Simon's opinion that offshore job stress was generally responsible for Decedent's heart attack is undermined by Dr. O'Meallie's opinion that there was nothing "deleterious in terms of psychological stress that makes an oil field worker more subject to it than anything else." Rather, Dr. O'Meallie's opinion that Decedent was "just as likely" to sustain a heart attack at home due to stress, which occurs at home and at work, is generally supported by Dr. Baker's opinion that individuals who retire often experience increased stress.

Further, as noted by the physicians, Decedent never reported a history of job stress to his treating physician which would indicate his work was related to his heart attack. Likewise, according to Mr. Priddy, Decedent related his condition to his lifestyle rather than work.

I find the unanimous agreement among the physicians that non-occupational factors increased the likelihood of Decedent's symptom reoccurrence supports Dr. O'Meallie's opinion that there is no evidence implying Decedent's work caused his death any more so than any factor that could have arisen at home. While the record fails to establish the extent, if any, which Decedent suffered from physical and psychological stresses aboard Employer's platform, the record unquestionably indicates Decedent continued gaining weight and using tobacco, which are non-occupational risks according to all of the physicians. Although Dr. Simon indicated Employer is partly responsible because it allowed Decedent to continue his lifestyle in the absence of his wife's attention, the record clearly establishes Decedent continued tobacco use and weight gain at home.

As noted above, Claimants contend Dr. O'Meallie's opinions are tantamount to a finding of "fault;" however, I find Dr. O'Meallie's conclusion is consistent with Dr. Baker's opinion

that non-occupational risks increase the likelihood of reoccurrence in the absence of "dramatic lifestyle changes." Consequently, I find Dr. O'Meallie's opinion simply illustrates decedent's ongoing lifestyle was not a unique condition of his occupation.

I find Dr. O'Meallie's uncontroverted opinion that sudden cardiac death might be caused under certain conditions immediately after unusual physical or psychological stress is generally consistent with established jurisprudence. In Donovan, supra, the Fifth Circuit noted the occurrence of a claimant's heart attack immediately following strenuous activities in itself raises an inference of a causal relationship between the activities and the attack. There, a claimant worked from 4:30 to 6:00 p.m. removing stairways from the bridge deck of a ship to the main deck, which was work that included cutting out a plate on the deck. After completing this job, the claimant was required to "burn out a frame in the shaft alley under the deck of another ship," where the claimant worked in a narrow, unventilated tunnel in which smoke was "so heavy that eight or nine other employees stopped work." The claimant "stuck it out until he completed his assignment" before a supper break, around 8:30 p.m., when he was unable to eat his supper. 175 F.2d at 744-745.

After the claimant's break in Donovan, the claimant had to enter a hole to "burn out brackets," which exposed him to more smoke, he "began feeling worse and worse." The claimant "twisted all kinds of ways," and performed all of his work on a scaffold thirty feet above ground, where he had to hold his heavy acetylene torch about twelve inches above his head. After he completed his job, "a little after midnight," he was nauseated, had "the shakes," and his legs "buckled." Co-workers put him in a stretcher, carried him to a wharf and called for an ambulance. Id.

In Donovan, the Court affirmed a finding that the heart attack was occupationally related. The Court specifically found substantial evidence supported an inference that "the physical strain to which [the claimant] was subjected and the lack of oxygen, caused by dense smoke and fumes in close quarters, were the straws that broke the camel's back." 175 F.2d at 745.

In the present matter, the facts do not establish Decedent suffered a heart attack immediately following strenuous activities. As discussed above, Decedent's co-workers described a "quiet day" in which there were no events "out of the

ordinary" which would have caused Decedent any particular stress. He was not required to run up and down stairs, but could take his time and rest, which the physicians agree may be a beneficial exercise. He complained of no chest pains to anybody. Rather, he looked "well" and concluded the day watching football with Mr. Fortenberry and possibly smoked a cigar. Accordingly, I find the record, which does not establish a so-called "straw that broke the camel's back," fails to establish an inference of a causal relationship between his activities and the heart attack.

Likewise, in Gooden v. Director, OWCP, 135 F.3d 1066 (5th Cir. 1998), 32 BRBS 59 (CRT), on which Claimants principally rely for the proposition that Decedent's heart attack is compensable, the claimant, who had pre-existing heart disease, suffered chest pains on October 31, 1990, "while physically lifting bags of rice that had fallen from a pallet," and again on November 13, 1990, "while lifting heavy bags that had fallen from their pallets." Although it was unclear when the claimant's chest pains began on November 13, 1990, isoenzyme analysis indicated Decedent suffered a myocardial infarction "several hours" before his initial blood sample was taken on November 13, 1990. 135 F.3d at 1067; 32 BRBS at 60-61.

The administrative law judge in Gooden concluded the event was not compensable because the "origins" of the claimant's underlying heart disease were not occupationally related, but the Court remanded for a determination whether the "heart attack itself" was compensable in consideration of Donovan, supra, and Southern Stevedoring Co. v. Henderson, 175 F.2d 863, 866 (5th Cir. 1949) (if a workman overstrains his powers, slight though they may be, or if something goes wrong with the human frame, such as the straining of a muscle or rupture of a blood vessel, an accident arises out of employment when the required exertion producing the injury is too great for the man undertaking the work, and the source of the force producing the injury need not be external). 135 F.3d at 1069; 32 BRBS at 61-62.

Unlike the facts presented in Gooden, the instant record contains no evidence establishing the internal or external "source of the force" of any injury which was "too great" for Decedent while he was undertaking work. At best, Dr. Baker offered an alternative "theory" that some insult might have occurred during the day to cause a rupture in Decedent's arteries which might have manifested as a heart attack during sleep; however, he specifically conceded there is no evidence supporting such a theory. Rather, he concluded the majority of

heart attacks occur at night as a natural progression of the disease. Moreover, he opined Decedent likely recovered from occupational stress before he retired for bed.

Likewise, Dr. O'Meallie specifically opined Decedent's occupational stress had "nothing to do with his heart disease or demise" in consideration of the passage of time between Decedent's work day and the onset of symptoms and in consideration of ongoing non-occupational risks. Coupled with Decedent's lack of complaints and the general descriptions of his co-workers, which fail to establish any physical or psychological stresses at work which precipitated his heart attack, I find the record insufficiently demonstrates a causal connection between Decedent's work and his heart attack.

Moreover, unlike Gooden, there is no evidence indicating when Decedent's myocardial infarction began. Rather, Dr. Simon opined Decedent suffered from prodromal symptoms related to non-occupational restenosis which may take "weeks" to manifest. There is no autopsy data establishing the events of Decedent's heart attack. As noted above, there is no evidence indicating Decedent was more likely to suffer a reoccurrence of symptoms due to the insertion of arterial stents. Likewise, the record indicates Decedent suffered no heart damage from his prior coronary complaints which predisposed him to further symptoms.

Further, while there is some disagreement between Dr. Simon and Drs. Baker and O'Meallie regarding the psychological and emotional stresses at work which affected Decedent's coronary artery disease, all of the physicians agree non-occupational risks, including tobacco use and obesity, increase the likelihood of a heart attack, which generally supports Dr. O'Meallie's opinion that there is no evidence implying Decedent's work caused his death any more so than any factor which could have arisen at home. Accordingly, I find the facts presented in Gooden are inapposite to the instant matter which fail to establish Decedent's occupation contributed to his heart attack.

In Ortco, supra, an administrative law judge denied death benefits in reliance upon the opinions of three physicians who concluded a decedent's fatal heart attack at work was not work-related. The Board reversed, noting the physicians could not "rule out" or "unequivocally" or "affirmatively" state the heart attack was not aggravated by working conditions. After the administrative law judge awarded benefits on remand, the matter ultimately percolated to the Fifth Circuit, which noted there is

no "ruling out" standard which an employer must survive in order to rebut the Section 20(a) presumption of compensability. 37 BRBS 35-39.

Rather, the Fifth Circuit found "the ALJ reached the right result the first time." Specifically, "under the proper standard of review, the ALJ's first holding, i.e., that [the claimant] was not entitled to [benefits under the Act], was supported by substantial evidence and was consistent with the law. That should have marked the end of the BRB's review." The Court added that, "at first blush, the aggravation rule might appear to weigh in favor of [the claimant's] claim;" however, the Court found that an application of the aggravation rule in a situation where a decedent's death at work was "coincidental" rather than "circumstantial" would "empty it of any meaning under the [Act]. The Court found the record established that the decedent suffered a heart attack which did not begin and end entirely in the context of the decedent's employment. Rather, he "brought the heart attack to work with him" in the morning after suffering ongoing symptoms which began at home and concluded in a fatal cardiac arrest fifteen minutes after going to work. 37 BRBS 39-40.

The Court in Ortco reversed the award of benefits, explaining:

> If an employee's pre-existing injury would **necessarily** be exacerbated by **any** activity regardless of where or when this activity takes place, and an employee happens to go to work, it is an impermissible leap of logic to say that there must be a causal connection between the worsening of the employee's injury and his work. There is a causal connection between the employee's **life** activity and his exacerbated injury, but it does not matter whether this activity happened to take place at work or elsewhere. To approve [benefits under the Act] in such cases would be to place a thumb on the scale in favor of [claimants under the Act]; yet the Supreme Court has expressly disapproved when, in the past, we weighted [the Act] to the advantage of claimants.

37 BRBS 35, 40-41 (CRT)(emphasis in original).

Claimants argue the holding of Ortco is inapplicable to the facts at hand because Decedent's heart attack occurred in toto aboard the offshore platform; however, they overlook Dr. Simon's opinion that Decedent probably suffered from prodromal symptoms from non-occupational restenosis, which take days or "weeks" to manifest, arguably implying the myocardial infarction began prior to Decedent's offshore stint. I disagree that the holding of Ortco should be entirely disregarded because Decedent's heart attack arguably occurred in toto on Employer's platform.

Moreover, I find Claimants' argument would require the undersigned to ignore the opinions of Drs. Baker and O'Meallie, who agreed there is no evidence establishing Decedent's heart attack was work-related. Their opinions are well-reasoned and supported by Mrs. Chauvin's testimony and the statements of Decedent's co-workers. Likewise, Claimants' argument would require the undersigned to discard persuasive evidence indicating Decedent's heart attack was "coincidental" in favor of poorly-supported evidence implying Decedent's job somehow "circumstantially" aggravated his underlying condition.

As noted above, all of the physicians generally agree non-occupational risks, including tobacco use and obesity, constitute a "causal connection between the employee's **life** activity and his exacerbated injury;" although there is some disagreement among Dr. Simon and Drs. Baker and O'Meallie regarding the contribution of Decedent's job conditions. Dr. Simon's speculative opinions that Decedent's job contributed to his heart attack are not persuasive in consideration of Mrs. Chauvin's testimony, the statements of Decedent's co-workers and the opinions of Drs. Baker and O'Meallie. Accordingly, I find a conclusion that there must be a causal connection between the worsening of the Decedent's condition and his work in reliance upon the less persuasive inferences afforded by Dr. Simon would be an "impermissible leap of logic" which would inappropriately weigh the record in favor of Claimants and which would be contrary to the holding of Greenwich Collieries, supra.

Additionally, I agree with Employer/Carrier that other matters decided by administrative law judges provide illustrative guidance for a resolution of this matter. In Kordell v. Global Terminals & Container Services, 21 BRBS 447 (ALJ) (1988), an administrative law judge denied death benefits, holding that a fatal heart attack was unrelated to the decedent's work and was a progression of his pre-existing coronary artery disease. The claimant argued decedent's occupation as a foreman, which did not expose him to heavy labor

as a longshoreman, exposed him to added stresses and strains which combined with his underlying pre-existing heart disease to cause the fatal heart attack. Witnesses noted the decedent was in charge of more men than usual on the day of his death, which allegedly created a heavier workload for the decedent, who looked tired during the morning before he died around lunch time. One physician opined the decedent's job was related to his heart attack based on reports that the decedent's job placed him under more stress than usual at work. 21 BRBS at 453.

In Kordell, the judge concluded the heart attack was related to the natural progression of the decedent's underlying heart disease, finding that a description of the Decedent's work did "not seem of a nature to constitute stress to such a degree that it would precipitate a fatal heart attack." The judge also found the opinion of the lone physician who opined there was a causal relationship between the decedent's job and his heart attack was diminished by the doctor's lack of knowledge of several essential aspects of the deceased's medical and work history, including the specifics of the deceased's job and whether the deceased was a smoker, had high cholesterol, suffered from hypertension, or had a relevant family history of related illnesses. 21 BRBS at 453-454.

Similarly, a review of the evidence regarding Decedent's work in the instant matter does not establish he faced stress to such a degree that it would precipitate a fatal heart attack. Although the doctors generally agreed stress might raise adrenaline levels which would create a complimentary rise in blood pressure, the facts indicate stress, if any, which Decedent suffered prior to his death abated by the time he retired for bed, as discussed above. I am not persuaded by the opinion of Dr. Simon, the only physician who opined there was a causal relationship between the decedent's job and his heart attack. As noted above, his description of Decedent's job conditions are inconsistent with Mr. Priddy's statements. Rather, I am persuaded by Dr. O'Meallie's opinions regarding the conditions of Decedent's employment which are consistent with the Decedent's co-workers' statements and which are based on greater familiarity with the demands of offshore work. Accordingly, I find the most reasonable inference from these facts suggests Decedent's heart attack was the result of the natural progression of his heart disease rather than unusual stresses related to Decedent's employment.

In Myers v. Energy Catering Services, Inc., 33 BRBS 285 (ALJ) (1999), an administrative law judge denied benefits where

the decedent died from acute coronary insufficiency due to atherosclerotic cardiovascular disease. Witnesses indicated the decedent had been feeling bad for the two days prior to his death. He complained of not sleeping and being overly tired. There was not much manual labor involved in the decedent's job and there had been no evidence presented of any employment conditions in the days before his death which could have caused, aggravated or accelerated Mr. Myers' condition. The only duties that were "sort of strenuous" occurred on grocery day. While the day before the decedent's death was grocery day, his only involvement was standing in the freezer and putting individual packages of meat on the shelves. In fact, other workers did most of the work while the decedent sat in a chair and dozed and tried to get better. Decedent complained of breathing difficulties before he went to bed some time after 11:30 p.m. Decedent subsequently died in his sleep around 3:30 a.m. 33 BRBS 290-291.

The judge in Myers determined the claimant failed to establish conditions which could have caused the heart attack sufficient to invoke the Section 20(a) presumption by providing no evidence of any strenuous activity or stressful situation associated with his employment which could have caused, aggravated or accelerated his condition in contradistinction to the matters decided in Obert v. John T. Clark and Son of Maryland, et al., 23 BRBS 157 (1990) (a claimant suffered angina and a myocardial infarction at home several days after moving 55-gallon drums at work and suffering chest pains in doing so) and Donovan, supra (physical complaints suffered concurrently with strenuous labor while cutting with an acetylene torch in close quarters).

Although the instant matter supports a conclusion that Claimants successfully invoked the Section 20(a) presumption under the Act, as noted above, I find they failed to establish a causal relationship between Decedent's work and his heart attack by a preponderance of the probative evidence of record for reasons analogous to the reasoning in Myers. Specifically, as noted above, the matter decided in Donovan, supra, involved the application of a reasonable inference which could be drawn between the occurrence of a decedent's heart attack and unusual stresses which immediately preceded the onset of symptoms. On these facts, which fail to establish such physical or psychological stresses immediately before the onset of symptoms, I find Claimants failed to establish Decedent's job was work-related.

Lastly, in Phillips v. Union Texas Petroleum, 27 BRBS 625 (ALJ), the undersigned considered an analogous set of facts involving the death of an employee who suffered from existing heart disease and died of a heart attack at his offshore job. There, witnesses indicated decedent, who smoked, was working during a "routine day on the rig with no outstanding projects on-going or anything out of the ordinary to accomplish." His job was not considered "physically demanding" because the most demanding tasks were walking up and down the stairs of a rig. He reported no complaints about "anything, including his work demands or health" during the day he died. The decedent did not do any strenuous work, other than climbing stairs, which would increase his heart rate. He was found collapsed near a well and flown ashore, where he was pronounced dead upon arrival at a hospital. 27 BRBS at 628-636.

In Phillips, as in the instant case, no persuasive medical opinion was expressed that decedent's heart attack was causally related to his working conditions as factually catalogued in this record. There was no supportive documentary evidence, including an autopsy report, to that effect. The record was "replete with negative evidence" dispelling the claimant's contentions of the work-relatedness of decedent's death. There was no evidence shown that decedent engaged in any physical activity on the day of his death that was "not ordinary or routine to his job functions." There was no showing that he engaged in any "unusual or unaccustomed physical activity which required him to strain or do heavy work." There was no evidence of "any acute stress, excitement or anxiety influencing decedent on the day of his death." 27 BRBS at 641.

On the other hand, the Phillips record, like the instant matter, supported a finding that the decedent had advanced coronary disease. The medical opinions revealed that the decedent's death may have occurred as a natural progression of the disease. There was no factual showing of any precipitating factor emanating from decedent's work environment. The medical opinions supported a conclusion that the decedent engaged in no incident or experience which was thought to precipitate a heart attack. 27 BRBS 641-642.

In the absence of facts favorable to the claimant in Phillips, as in the instant matter, medical opinion that the decedent's death was possibly related to his work environment, without any factual predicate or hypothetical parameters therefor, was tantamount to a substitution of speculation for evidence. I concluded in Phillips, as I do here, that there

must be "some showing, no matter how circumstantial, that there is a factual connectivity or on-going unexpected experience between the decedent's death and his employment." Id.

The preponderance of medical opinions in this matter fails to establish a causal relationship between Decedent's heart attack and employment, as discussed more thoroughly above. To conclude otherwise would read the "arises out of" provision completely out of the Act in reliance only upon a showing that decedent was in the course of his employment at the time of his death. In an effort to achieve a humanitarian result, I cannot decide the matter purely on the basis of compassion.

After weighing the totality of the record evidence, I conclude that decedent's death on October 5, 1998, was due to his underlying coronary disease to which he was predisposed and that no causal connection to his work activities exists. Accordingly, I further conclude, weighing the evidence as a whole, that decedent's death did not arise out of his employment and thus is not a compensable injury under Section 2(2) of the Act.

b. Lack of Emergency Medical Care/Defibrillator

Having found Decedent did not suffer a compensable injury under the Act, I find Claimants' argument that Employer should have provided a defibrillator aboard its platform is without merit in establishing entitlement to death benefits. Nevertheless, for the purposes of explication, I find Dr. Simon's opinion that a defibrillator should have been aboard the platform is not persuasive in establishing Decedent would have survived his condition and ordeal.

Prefatorily, Dr. Simon conceded automatic portable defibrillators which are becoming more commonplace in various industries were not commonly used in the workplace when Decedent suffered his heart attack. His testimony that the older defibrillators were commonplace in hospitals and aboard ambulances fails to establish the presence of such a device could have prevented Decedent's death. Although Mr. Priddy indicated Mr. Teel was trained in the use of electric paddles and would have used them on Decedent had they been available is not supported by Mr. Teel's statement. Otherwise, there is no evidence indicating individuals aboard Employer's platform could use an older defibrillator. Further, there is no indication in the record that the use of a defibrillator would have been successful.

Dr. Simon candidly professed ignorance of the severity of Decedent's heart attack or whether Decedent's condition was even reversible with a successful defibrillation. Dr. O'Meallie's uncontroverted opinion that a successful defibrillation may not be effective if the underlying substrate causing the condition is not remedied undermines Dr. Simon's assumption. In the present matter, Dr. Simon opined Decedent suffered from non-occupational restenosis which probably caused his death. Accordingly, I find Dr. Simon's opinion that Decedent "would not have died at the time he died had he been successfully defibrillated in three minutes or less" fails to establish the occlusion causing Decedent's symptoms could have been remedied timely to prevent death through the use of a defibrillator.

Further, although Dr. O'Meallie opined a successful defibrillation is technically considered prolonging life, it is questionable whether quicker treatment with such a device would have been helpful. Dr. Simon's opinion presupposes Decedent suffered a coronary event which would have positively responded to quick treatment with a defibrillator. The record, which is devoid of autopsy evidence, does not establish Decedent suffered ventricular fibrillation which would have been successfully treated with a defibrillator. Dr. Baker clearly opined Decedent suffered from cardiogenic shock, which is "rarely" reversed and which does not mean quicker response will alter the outcome of the malady. Meanwhile, Dr. O'Meallie opined Decedent suffered "sudden cardiac death," which involves the deprivation of coronary blood supply. As discussed above, there is no evidence establishing that a successful defibrillation, which may correct arrhythmia, would remedy the deprivation of coronary blood supply.

Accordingly, I find Dr. Simon's factually unsupported speculation fails to establish that quicker medical treatment with the use of a defibrillator aboard Employer's platform would have altered the outcome of Decedent's condition.

c. The Use of a Private Helicopter Service

I find Claimants' argument that Employer's decision to forego the use of a USCG helicopter service fails to establish Decedent would have benefited from USCG helicopter service. Claimants concede there is no evidence defibrillators were present aboard helicopters which were allegedly available with the USCG. At best, they contend it is reasonable to assume the devices were supplied on the helicopters because hospitals and

ambulances regularly provided the machines; however, such an assumption is factually unsupported in the record. Moreover, the scant USCG evidence presented by Claimants fails to establish the USCG helicopter service would have arrived timely and provided life sustaining support.

Mr. Priddy estimated the USCG would have taken "approximately one hour" to arrive at the platform. Although the facts are unclear, it appears a call for helicopter service occurred around 2:10 a.m. By Mr. Priddy's estimate, the helicopter service would have arrived at 3:10 a.m., which is arguably 25 minutes after Decedent lost his pulse and quit breathing at around 2:45 a.m. Claimants contend the USCG could have arrived by 2:10 a.m. had USCG been notified; however, a review of the USCG records, which indicate a flight crew could contact a flight surgeon and be launched immediately, reveals insufficient evidence establishing the length of time the USCG helicopter service required to reach Employer's platform under the prevailing weather conditions on the night Decedent died.

In light of the foregoing, I find Claimants' argument is based on factually unsupported speculation, which fails to establish Decedent's death could have been prevented by the decision to request USCG transportation.

d. The Location of Employer's Platform

Of the record physicians, Dr. Simon uniquely opined that Decedent's location on Employer's platform accelerated his death. I find his opinion that Decedent would have survived onshore because a rescue squad could have been dispatched timely to arrive by 2:15 a.m. or 2:20 a.m., when Decedent could have been "on a monitor either in the back of an ambulance or in the emergency room by the time he defibrillated at approximately 2:45 a.m" is undermined by his estimation that there is only a twenty percent chance of survival upon the occurrence of ventricular fibrillation outside of a hospital environment. Otherwise, I find his opinion is exceedingly speculative and lacks factual support establishing the assumptions on which he relied would occur to result in life-sustaining medical treatment. Rather, I am persuaded by the facts presented in this record and the medical opinions of Drs. O'Meallie and Baker to conclude Decedent's offshore employment was unrelated to his death.

VII. ATTORNEY'S FEES

No award of attorney's fees for services to the Claimant is made herein because Claimants failed to successfully prosecute the issues for resolution.

VIII. ORDER

Based upon the foregoing Findings of Fact, Conclusions of Law, and upon the entire record, Claimants' claim for death benefits is hereby **DENIED.**

ORDERED this 26th day of March, 2004, at Metairie, Louisiana.

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LEE J. ROMERO, JR.
Administrative Law Judge